ADNIC
شركة أبوظبي الوطنية للتأمين
ABU DHABI NATIONAL INSURANCE COMPANY

REIMBURSEMENT MEDICAL CLAIM FORM

Please read the instructions & guidelines on overleaf before filling out the form

Voucher No.:

1. Patient's name (as mentioned on the insurance card) :

2. Patient's Health Card No. or Emirates ID No.:

3. Group member's name (if applicable) :

4. Reason for not using listed Healthcare facilities: (kindly indicate)

☐ Emergency ☐ Elective ☐ Service not available ☐ On vacation/business trip outside the UAE

☐ Other(s) please specify _____

5. Medical information: (To be filled by treating doctor for all outpatient treatment. For cases like hospitalization procedures and surgeries, a detailed medical report is required)

Condition requiring treatment:	**Visit date:**

Onset and duration of illness:

Treatment details:

I declare that I have attended to this patient and that the particulars given are to the best of my knowledge true and correct.

Name & signature of the doctor: _____ Date: _____ Stamp: _____

6. Name & Address of the Hospital/Clinic	Bill No.	Treatment Date	Description of Services	Amount

Currency (If treatment availed outside the UAE) _____ **TOTAL** _____

7. Other information:

Is the above case work-related? ☐ No ☐ Yes (full details) _____

Is the claim covered by another insurance? ☐ No ☐ Yes (Please specify the amount reimbursed and by which insurance company) _____

8. Declaration:

I hereby declare that I am the patient/patient's legal guardian (if the patient is under 18 years of old).

I agree to submit to ADNIC any mandatory/deemed necessary requested document to process my above claim. I hereby authorize ADNIC to approach any doctor/medical facility/any institution or any person who has any record/medical information about me or my family member, to provide ADNIC with complete information including copies of the records when requested.

I, the undersigned, hereby declare that the information submitted is correct and that the reimbursement requested is for the costs and expenses paid by me for the treatment of my covered condition. I understand that it is unlawful to provide false, incomplete and/or misleading facts and information (misrepresentation) to ADNIC for the purpose to defraud or attempt to defraud ADNIC. I further understand that such act may lead to imprisonment, fines, denial of coverage, loss of benefits or termination of the Insurance Policy.

I, the Undersigned, hereby declare that I have read and understood the instructions stated in pages 2 and 3 below, and I confirm that I am fully aware of the directions and requirements mentioned hereinafter.

I hereby discharge ADNIC from any liability with respect of releasing the payment to the bank details specified by me below.

Name (Name of the card holder or name of legal guardian or legal representative)	Signature	Date	Contact No.	Email address

P.O.Box 839 - Abu Dhabi, U.A.E. Tel: +971 (0) 2 4080100 Fax: +971 (0) 2 4080604 • www.adnic.ae • Toll free: 800 8040 :الهاتف المجاني: 839 - أبو ظبي، الإمارات العربية المتحدة - هاتف: 4080100 2 (0) 971+ فاكس: 4080604 2 (0) 971+ •

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Instructions

1. This form needs to be completed by the insured member (Card holder).
2. Please read the form carefully and make sure to complete all pertinent information. ADNIC will not be able to process any incomplete Reimbursement Claim Form that lacks proper documentation.
3. Use a separate form for each Member.
4. All the documents including invoices and medical reports should be in either English or Arabic. Documents in other languages must be translated by an official public translator prior to submission.
5. The following documents to be attached to your duly filled Reimbursement Claim Form:
   (Failure to provide any of the required documents may result in rejection or delay in the processing of the claim)
   - Copy of Medical insurance card or Emirates ID
   - Original itemized bill/invoices (dated) or receipts of payment (dated)
   - Original prescription for medication given by the treating doctor (except for controlled drugs). Validity of the prescription is limited to 60 days from the date of issue and for controlled drugs limited to 3 days from the date of issue in line with the Regulator
   - Investigation requests/reports like laboratory tests, x-rays, etc

   Additional requirements to above:

   For Inpatient (Hospitalization Cases):
   - Medical Report/Discharge Summary stamped & signed by the treating doctor.

   For treatments availed Outside the UAE:
   - Proof of travel with date (E.g.: Copy of tickets/Boarding pass/Exit & Entry page).
   - Elective treatment is subject to ADNIC prior approval at all times.
6. Please retain copies of receipts and documents enclosed with your claim, as ADNIC will retain original documents.
7. All claims subject to reimbursement availed inside or outside the UAE, should be submitted within 120 days of incurred treatment date.
8. Please submit all the above required documents directly to: **medicalclaims@adnic.ae**

If you need assistance in filling this form, please call: 8008040

Instructions to complete the form:

1. **Please write your name & Medical insurance card number** as mentioned in the Card.
2. **Medical Information -** Request your treating doctor to fill up brief medical information about your condition and treatment.
3. **Provider Name & Address -** Kindly use more than one line if necessary to provide this information about each facility where you were treated.
4. **Bill No. -** Please write the serial number/reference number printed on the bill/receipt/invoice for each service separately.
5. **Service Date -** State date of treatment for each service against each bill.
6. **Description of services -** State type of service like consultation/Pharmacy/Investigations/Physiotherapy/Dental/ Hospitalization.
7. **Amount** – State the exact amount as appears on the invoices.
8. **Total** – Total amount of all the invoices submitted with this form for reimbursement from ADNIC.
9. **Currency** – Name of the currency in which actual payment was made.
10. If treatment is due to a road traffic accident, a police report is required to be submitted with this form.
11. **Declaration:** Kindly write your name, signature, date, the contact number and relationship to the cardholder.

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PREFERENCE – MODE OF SETTLEMENT

1. ☐ Cheque

2. ☐ Bank/Wire Transfer

If Bank/Wire Transfer, please fill in the below authorization form.

AUTHORIZATION FORM FOR BANK/WIRE TRANSFER

I, the undersigned, hereby authorize Abu Dhabi National Insurance Company (ADNIC) to make a wire transfer of the amount of my claim under this form to the following bank account and hereby discharge ADNIC from any liability with respect of releasing the payment to the bank details specified by me below:

BANK NAME: _____

IBAN NUMBER: _____

EMAIL ID: _____

MOBILE NUMBER: _____

_____	_____	_____
Member Name & Medical insurance card number	Signature	Date

Disclaimer: All information provided is the responsibility of the member and is legally binding.

ADNIC OPS only

ADNIC staff name: _____ Date: _____

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